		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035477

Facility Name: Exceptional Care & Training Center

Address: 2601 Woodlawn Road (Number) Sterling (City) 61081 (Zip Code)

County: Whiteside

Telephone Number: (815) 626-8520 **Fax #** (815) 626-8075

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) James R. Johnson
(Title) V.P. of Finance - Jefferson Medical Rehab. Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title) Robert A. Thomas, Partner
(Firm Name & Address) Thomas Healthcare Consulting, P.C., 11711 Meridian Street, Suite 725, Carmel, IN 46032
(Telephone) (317) 580-8301 Fax # (317) 580-8310

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	79	Skilled Pediatric (SNF/PED)	79	28,835	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	79	TOTALS	79	28,835	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	28,661			28,661	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	28,661			28,661	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 99.40%

D. How many bed-hold days during this year were paid by Public Aid? 79 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	159,663	18,218	4,286	182,167		182,167	(20)	182,147			1
2	Food Purchase		113,398		113,398		113,398		113,398			2
3	Housekeeping	92,706	10,427		103,133		103,133		103,133			3
4	Laundry	120,128	15,242		135,370		135,370		135,370			4
5	Heat and Other Utilities			75,131	75,131		75,131		75,131			5
6	Maintenance	62,537	7,760	22,188	92,485		92,485		92,485			6
7	Other (specify):*											7
8	**TOTAL General Services**	435,034	165,045	101,605	701,684		701,684	(20)	701,664			8
	B. Health Care and Programs											
9	Medical Director			12,600	12,600		12,600		12,600			9
10	Nursing and Medical Records	1,384,150	50,275	8,049	1,442,474	27,084	1,469,558		1,469,558			10
10a	Therapy	14,079		10,077	24,156		24,156		24,156			10a
11	Activities	159,552	2,129		161,681		161,681		161,681			11
12	Social Services			4,861	4,861	(4,861)						12
13	Nurse Aide Training	41,319			41,319	(26,202)	15,117		15,117			13
14	Program Transportation		637	843	1,480		1,480		1,480			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,599,100	53,041	36,430	1,688,571	(3,979)	1,684,592		1,684,592			16
	C. General Administration											
17	Administrative	57,085		113,694	170,779	(113,725)	57,054	31	57,085			17
18	Directors Fees					6,958	6,958		6,958			18
19	Professional Services			332,511	332,511	36,027	368,538		368,538			19
20	Dues, Fees, Subscriptions & Promotions			13,065	13,065	595	13,660	(1,454)	12,206			20
21	Clerical & General Office Expenses	49,879	12,234	9,836	71,949	32,533	104,482		104,482			21
22	Employee Benefits & Payroll Taxes			721,593	721,593	3,901	725,494		725,494			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,759	5,759	(146)	5,613		5,613			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			21,863	21,863		21,863		21,863			26
27	Other (specify):* Bad Debt			4,400	4,400		4,400	(4,400)				27
28	**TOTAL General Administration**	106,964	12,234	1,222,721	1,341,919	(33,857)	1,308,062	(5,823)	1,302,239			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,141,098	230,320	1,360,756	3,732,174	(37,836)	3,694,338	(5,843)	3,688,495			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Exceptional Care & Training Center #0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			130,285	130,285	89	130,374		130,374			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			356,822	356,822	37,998	394,820	(26,697)	368,123			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,958	2,958	(251)	2,707		2,707			35
36	Other (specify):* **Amortization**			29,581	29,581		29,581	(20,759)	8,822			36
37	**TOTAL Ownership**			519,646	519,646	37,836	557,482	(47,456)	510,026			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			261,832	261,832		261,832		261,832			42
43	Other (specify):* **Day Training**	547,077	11,984	91,105	650,166		650,166		650,166			43
44	**TOTAL Special Cost Centers**	547,077	11,984	352,937	911,998		911,998		911,998			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,688,175	242,304	2,233,339	5,163,818		5,163,818	(53,299)	5,110,519			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(26,697)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,400)	27		24
25	Fund Raising, Advertising and Promotional	(1,454)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Goodwill	(20,759)	36		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (53,330)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	31		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 31		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (53,299)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Exceptional Care & Training Center

ID# 0035477

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Goodwill	$ (20,759)	36	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(20,759)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(20)	0	0	0	0	0	0	0	0	0	0	(20)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(20)	0	0	0	0	0	0	0	0	0	0	(20)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	31	0	0	0	0	0	0	0	0	0	31	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,454)	0	0	0	0	0	0	0	0	0	0	(1,454)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,400)	0	0	0	0	0	0	0	0	0	0	(4,400)	27
28	**TOTAL General Administration**	(5,854)	31	0	0	0	0	0	0	0	0	0	(5,823)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(5,874)	31	0	0	0	0	0	0	0	0	0	(5,843)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Exceptional Care & Training Center** **#** **0035477** **Report Period Beginning:** **07/01/01** **Ending:** **06/30/02**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,697)	0	0	0	0	0	0	0	0	0	0	(26,697)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(20,759)	0	0	0	0	0	0	0	0	0	0	(20,759)	36
37	**TOTAL Ownership**	(47,456)	0	0	0	0	0	0	0	0	0	0	(47,456)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(53,330)	31	0	0	0	0	0	0	0	0	0	(53,299)	45

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Swann Special Care Center	Champaign			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	$ 113,694	Hoosier Care, Inc.	100.00%	$ 113,725	$ 31	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 113,694			$ 113,725	$ * 31	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	7,931			Director Fees	$ 1,392	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,931			Director Fees	1,392	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,931			Director Fees	1,392	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,932			Director Fees	1,391	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,932			Director Fees	1,391	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 6,958		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, KY 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Director's Fees	Revenue	40,133,041	8	$ 46,615	$ 0	5,990,673	$ 6,958	1
2	19	Professional Fees	Revenue	40,133,041	8	241,351	0	5,990,673	36,027	2
3	20	Fees,Subscription & Promotion	Revenue	40,133,041	8	923	0	5,990,673	138	3
4	21	Clerical & General Office Exp.	Revenue	40,133,041	8	183,702	0	5,990,673	27,421	4
5	22	Emp. Benefits & Payroll Tax	Revenue	40,133,041	8	26,136	0	5,990,673	3,901	5
6	24	Travel & Seminar	Revenue	40,133,041	8	7,990	0	5,990,673	1,193	6
7	30	Depreciation	Revenue	40,133,041	8	597	0	5,990,673	89	7
8	32	Interest Expense	Revenue	40,133,041	8	254,560	0	5,990,673	37,998	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 761,874	$		$ 113,725	25

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	City of Sterling Bonds-1999A		X	Purchase of Facility	Varies	07/08/99	$ 4,775,000	$ 4,670,000	06/01/2034	7.1250	$ 334,816	1
2	City of Sterling Bonds-1999B		X	Purchase of Facility	Varies	07/08/99	220,000	210,000	06/01/2019	10.5000	22,006	2
3												3
4												4
5												5
	Working Capital											
6	Home Office Allocation										37,998	6
7												7
8												8
9	**TOTAL Facility Related**						$ 4,995,000	$ 4,880,000			$ 394,820	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	**TOTAL Non-Facility Related**						$	$			$	14
15	**TOTALS (line 9+line14)**						$ 4,995,000	$ 4,880,000			$ 394,820	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** **N/A** **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	None	8
1998		9
1999		10
2000		11
2001		12

Note: The facility became exempt from property taxes starting 1/1/96.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Exceptional Care & Training Center COUNTY Whiteside

FACILITY IDPH LICENSE NUMBER 0035477

CONTACT PERSON REGARDING THIS REPORT James R. Johnson

TELEPHONE (859) 255-0075 FAX #: (859) 281-5150

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not Applicable		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,676 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED	63,598	1989	$ 414,085	1
2					2
3	TOTALS	63,598		$ 414,085	3

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1989		$ 2,334,000	$ 58,000	10-35	$ 58,000	$	$ 1,053,166	4
5	15			1991	358,311	11,944	30	11,944		131,935	5
6											6
7											7
8											8
	Improvement Type**										
9	Boiler Repair			1990	964		10			964	9
10	Water Unit			1991	8,780		10			8,780	10
11	PA System			1991	696		10			696	11
12	Building Addition - Drywall			1991	403		10			403	12
13	Closet Curtain Track			1991	650	5	10	5		650	13
14	Door			1991	1,614	67	10	67		1,614	14
15	Boiler Repair			1992	6,180	343	10	343		6,180	15
16	Storm Windows			1992	907	53	10	53		907	16
17	Boiler Tubes			1992	7,147	476	10	476		7,147	17
18	Roof			1992	11,118	741	10	741		11,118	18
19	Kitchen Tile			1992	3,660	275	10	275		3,660	19
20	Heating & Cooling Unit			1992	7,757	711	10	711		7,757	20
21	Shed			1992	1,678	140	10	140		1,678	21
22	Gate & Fence Scars			1992	4,038	337	10	337		4,038	22
23	Landscaping			1992	2,398	220	10	220		2,398	23
24	Drain Replacement			1992	1,576	79	10	79		1,576	24
25	Black Top			1992	575	57	10	57		562	25
26	Light Fixtures			1992	3,743	374	10	374		3,743	26
27	Building Renovation			1993	139	5	30	5		49	27
28	Painting - Laundry			1993	351	35	10	35		351	28
29	Building Renovation			1993	7,106	711	10	711		6,575	29
30	Painting - Laundry			1993	262	26	10	26		241	30
31	Parking Lot			1993	1,800	180	10	180		1,635	31
32	Tile Installation			1993	1,020	102	10	102		941	32
33	Electrical Work			1993	3,255	326	10	326		3,014	33
34	Pipe Installation - Laundry			1993	156	16	10	16		145	34
35	Water Heater Renovation			1993	849	85	10	85		772	35
36	Final Payment - Laundry			1993	1,030	103	10	103		935	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Replace Relay in Panel	1993	$ 1,150	$ 115	10	$ 115	$	$ 1,016	37
38	Install New Sewer Lines	1993	4,105	411	10	411		3,698	38
39	New Water Main	1993	12,204	1,220	10	1,220		10,680	39
40	Replace Parts on Sump Pumps	1994	4,034	403	10	403		3,294	40
41	Installed Back Flow Preventor	1994	1,053	105	10	105		842	41
42	Large Toilet Support, Back Stop	1994	923	92	10	92		713	42
43	Deck	1994	814	81	10	81		621	43
44	New Roof	1994	29,435	2,943	10	2,943		21,827	44
45	Tile Floors in Tub Room	1994	4,405	441	10	441		3,271	45
46	Thermocouple on Boiler	1995	2,550	255	10	255		1,870	46
47	New Pump on Boiler System	1995	1,706	171	10	171		1,225	47
48	Air Conditioner Compressor	1995	1,668	167	10	167		1,183	48
49	Replace Fire Alarm	1995	3,743	374	10	374		2,649	49
50	Landscaping	1995	15,000	1,500	10	1,500		10,625	50
51	Counter Top	1995	527	53	10	53		397	51
52	New Door Frame Installed	1995	959	96	10	96		640	52
53	Rebuild Corner of Building	1996	2,000	200	10	200		1,250	53
54	Install Two Bell - Strobes	1996	888	89	10	89		556	54
55	Replace Relay & Timer on Generator	1996	1,325	132	10	132		792	55
56	Rebuild Commercial Water Softener	1996	1,880	188	10	188		1,269	56
57	Replace 3/4 H.P. Motor, Thermocoupler	1996	920	92	10	92		552	57
58	Replace Boiler Pumps and Bearing Assembly	1997	640	64	10	64		347	58
59	Install 3/4 H.P. Motor-Boiler	1997	725	72	10	72		378	59
60	Replace Circulating Pump, Bearings	1997	743	74	10	74		389	60
61	Twenty New Water Faucets	1997	2,296	230	10	230		1,188	61
62	Vinyl Floor Tile-Resident Room	1997	690	69	10	69		351	62
63	Reseal Parking Area	1997	2,845	285	10	285		1,449	63
64	Air Conditioning Condenser Unit	1997	1,650	165	10	165		798	64
65	Install Conduit	1997	913	91	10	91		432	65
66	Outlets & Wiring	1997	522	52	10	52		242	66
67	Kitchen Fire Suppression System	1998	767	77	10	77		340	67
68	Smoke Detectors	1998	621	62	10	62		274	68
69	Install Pipe & Wire	1998	995	99	10	99		429	69
70	TOTAL (lines 4 thru 69)		$ 2,876,859	$ 85,879		$ 85,879	$	$ 1,339,217	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,876,859	$ 85,879		$ 85,879	$	$ 1,339,217	1
2	Smoke Detectors	1998	1,644	165	10	165		716	2
3	Tank Replacement - PIPECO	1998	9,890	495	20	495		1,897	3
4	Generator and Transfer Switch Changeover	1998	2,746	275	10	275		1,054	4
5	Replace Tubes on Boiler, Galv. Pipes on Water Line	1998	1,690	169	10	169		620	5
6	Installed Boiler Control and Switch for Light	1998	709	71	10	71		266	6
7	Replace Faulty Smoke Detectors, Installed Batteries	1998	973	97	10	97		364	7
8	Installed Tile on Walls & in Staircase (New Addition)	1998	4,495	450	10	450		1,612	8
9	Two Hot Water Tanks Installed	1999	7,119	712	10	712		2,373	9
10	Installation Heavier Electric Service for Dishwasher	1999	1,651	165	10	165		550	10
11	Install New Cooling System Laundry / Kitchen	2000	4,650	233	20	233		582	11
12	Plaster & Drywall existing walls in Residents Rooms	2000	800	80	10	80		193	12
13	Install New Tile in Dinning Area & Two Classrooms	2000	4,770	318	15	318		716	13
14	Installed New Thermocuople on West Boiler	2000	353	35	10	35		79	14
15	Replace Thermocouple on West Boiler	2000	140	14	10	14		31	15
16	Replace Thermocouple on Inducer Fan	2000	215	21	10	21		47	16
17	Rebuilt two hopper foot valves / Installed Protectorelay	2000	1,430	143	10	143		322	17
18	Replace Coupler, Motor Mounts, Bearing assy, Impeller	2000	298	30	10	30		67	18
19	Labor to Install 120V Power to New Door Openers	2000	583	58	10	58		126	19
20	Replaced Bearing Assy on Hot Water Return Line	2000	518	52	10	52		113	20
21	Indicator Lamps & Voltage	2000	1,525	153	10	153		267	21
22	Replace Heat Exchanger	2001	962	96	10	96		144	22
23	Replace Heat Exchanger	2001	962	96	10	96		136	23
24	Replace Draft Inducer	2001	1,414	141	10	141		188	24
25	Replace Pipe	2001	530	53	10	53		71	25
26	Replace Clinical Sink	2001	2,304	154	15	154		192	26
27	Furnish & Install Awning	2001	2,771	185	15	185		231	27
28	Labor & Mat-Breaker Panel	2001	3,930	262	15	262		327	28
29	Install Thermo Coupler	2001	944	94	10	94		110	29
30	Install Electric For Dishwasher	2001	820	55	15	55		64	30
31	Reroof Facility and Garage	2001	13,960	558	25	558		651	31
32	Lusterboard Sign	2001	515	103	5	103		112	32
33	Excavation of New Parking	2001	12,415	621	20	621		724	33
34	TOTAL (lines 1 thru 33)		$ 2,964,585	$ 92,033		$ 92,033	$	$ 1,354,162	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,964,585	$ 92,033		$ 92,033	$	$ 1,354,162	1
2	Renovation Installment	2001	63,363	12,673	5	12,673		17,953	2
3	Concrete for Canapy & Add.	2001	2,592	519	5	519		692	3
4	Reconfigure Changing area	2001	3,393	509	5	509		509	4
5	Refund Electrical Panel	2001	(975)	(195)	5	(195)		(195)	5
6	Install Water Heater	2001	3,341	223	15	223		223	6
7	Conduit & Wiring for Door Holders	2001	1,982	132	15	132		132	7
8	Air Conditioning in Lobby-Motor Replacement	2001	349	32	10	32		32	8
9	East Tub Room Fan-Motor Replacement	2001	213	20	10	20		20	9
10	Dryer Vent Replacement	2001	319	29	10	29		29	10
11	Reconfigure Water Heater Room	2001	1,860	103	15	103		103	11
12	Walkway	2001	4,120	252	15	252		252	12
13	Hand Railing on Stairs to Upper Parking Lot	2002	2,130	35	15	35		35	13
14	Privacy Fence	2002	2,550	21	10	21		21	14
15	Install Temp Control Cartridge-Boiler	2002	537	18	15	18		18	15
16	Internet Set Up Wiring, Cable	2002	3,061	85	10	85		85	16
17	Motor Boiler	2002	763	25	10	25		25	17
18	Replace Hallow Metal Door	2002	1,665	9	15	9		9	18
19	Shutters	2002	820	7	10	7		7	19
20	Storm Window Project	2002	8,937	37	20	37		37	20
21	Replace Breaker, Ballasts	2002	555	55	5	55		55	21
22	Tennant Allowance to Offset Fix-up Costs	2002	(5,000)	(500)	5	(500)		(500)	22
23	Rounding			(1)		(1)		(5)	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,061,160	$ 106,121		$ 106,121	$	$ 1,373,699	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 92,619	$ 15,142	$ 15,142	$		$ 40,730	71
72	Current Year Purchases	27,313	2,018	2,018			2,018	72
73	Fully Depreciated Assets	372,634	847	847			372,634	73
74	Corporate Allocation		89	89				74
75	TOTALS	$ 492,566	$ 18,096	$ 18,096	$		$ 415,382	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	Van Renovation	1991	$ 5,840	$	$	$	3	$ 5,840	76
77	Patient Transportation	1995 Ford Van	1998	2,071	414	414		5	1,484	77
78	Patient Transportation	1985 GMC Bus	2000	26,150	5,230	5,230		5	9,152	78
79	Patient Transportation	2002 Van	2002	30,758	513	513		5	513	79
80	TOTALS			$ 64,819	$ 6,157	$ 6,157	$		$ 16,989	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,032,630	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,374	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,374	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,806,070	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 2,707 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	64

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		882		882
3	Classroom Wages (a)		4,550		4,550
4	Clinical Wages (b)		7,280		7,280
5	In-House Trainer Wages (c)		2,405		2,405
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 15,117	$	$ 15,117
10	SUM OF line 9, col. 1 and 2 (e)	$ 15,117			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Exceptional Care & Training Center # 0035477 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,604	$	1
2	Cash-Patient Deposits	59,506		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,700)	1,428,494		3
4	Supply Inventory (priced at Cost)	7,656		4
5	Short-Term Investments			5
6	Prepaid Insurance	(174,382)		6
7	Other Prepaid Expenses	3,178		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	6,110,551		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,436,607	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	414,085		13
14	Buildings, at Historical Cost	3,061,160		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	557,385		16
17	Accumulated Depreciation (book methods)	(1,806,070)		17
18	Deferred Charges	282,297		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,188		21
22	Other Long-Term Assets (specify):	541,878		22
23	Other(specify): Goodwill	562,227		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,615,150	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,051,757	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 36,428	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	59,506		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	135,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	35,992		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	29,522		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 296,677	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,880,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,880,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,176,677	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,875,080	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,051,757	$	48

***(See instructions.)**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,021,528	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,021,528	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	853,551	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 853,552	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,875,080	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,617,165	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,617,165	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	18,448	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	20	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,468	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,697	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,697	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	1,354,800	28
28a	Miscellaneous Income	239	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,355,039	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,017,369	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	701,684	31
32	Health Care	1,688,571	32
33	General Administration	1,341,919	33
	B. Capital Expense		
34	Ownership	519,646	34
	C. Ancillary Expense		
35	Special Cost Centers	650,166	35
36	Provider Participation Fee	261,832	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,163,818	40
41	**Income before Income Taxes (line 30 minus line 40)****	853,551	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 853,551	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,909	2,086	$ 44,679	$ 21.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,483	3,999	78,944	19.74	3
4	Licensed Practical Nurses	19,717	22,319	344,720	15.45	4
5	Nurse Aides & Orderlies	86,380	94,073	942,891	10.02	5
6	Nurse Aide Trainees	1,741	1,768	14,235	8.05	6
7	Licensed Therapist	787	805	14,079	17.49	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,850	2,136	31,824	14.90	9
10	Activity Assistants	16,097	17,770	127,728	7.19	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,966	2,086	34,456	16.52	13
14	Head Cook	6,135	6,885	70,314	10.21	14
15	Cook Helpers/Assistants	6,230	6,789	54,893	8.09	15
16	Dishwashers					16
17	Maintenance Workers	4,203	4,755	62,537	13.15	17
18	Housekeepers	8,975	10,328	92,706	8.98	18
19	Laundry	11,256	12,836	120,128	9.36	19
20	Administrator	1,940	2,086	57,085	27.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,172	4,483	49,879	11.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	47,487	53,514	547,077	10.22	33
34	TOTAL (lines 1 - 33)	224,328	248,718	$ 2,688,175 *	$ 10.81	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 3,803	1.3	35
36	Medical Director	96	12,600	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	288	1,800	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	251	10,077	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Dental Fees	N/A	6,249	10.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	755	$ 34,529		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Melissa Blaine	Administrator	0	$ 57,085
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,085

B. Administrative - Other

Description	Amount
Corporate Expenses	$ 113,694
TOTAL (agree to Schedule V, line 17, col. 3)	$ 113,694
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jefferson Medical Rehabilitation		$
Centers, Inc.	Management Fees	327,600
Katz, Sapper & Miller, LLP	Accounting Fees	3,400
Duane Morris, LLP	Legal Fees	1,511
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 332,511

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 313,918
Unemployment Compensation Insurance	8,137
FICA Taxes	195,072
Employee Health Insurance	189,761
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	14,705
Corporate Allocation	3,901
TOTAL (agree to Schedule V, line 22, col.8)	$ 725,494

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 100
Advertising: Employee Recruitment	
Health Care Worker Background Check	1,042
(Indicate # of checks performed 84)	
Illinois Health Care Assoc.	3,382
MES of Illinois	175
NAEIR	575
Corporate Allocation	138
Chamber of Commerce	461
Other Fees (See Attached)	7,787
Less: Public Relations Expense	(993)
Non-allowable advertising	(461)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,206

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,088
Seminar Expense	2,332
Corporate Allocation	1,193
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,613

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	None		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Exceptional Care & Training Center # 0035477 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,321** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **261,832**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **47,263**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PriceWaterhouseCoopers** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.